EXECUTIVE SUMMARY

PURPOSE

To describe the Medicare Part B services provided to nursing home residents and to identify and discuss known or potential program vulnerabilities.

BACKGROUND

Medicare Part B covers a wide range of medical services and supplies for the program's beneficiaries, including those in nursing homes. These services include physician services and outpatient hospital services, diagnostic laboratory tests, imaging, ambulance services, and a wide range of medical equipment and supplies.

We obtained information about Part B expenditures from a 1992 nationally projectable sample of nursing home residents from 10 States and 150 nursing homes. This includes residents receiving Medicare extended care benefits in a skilled nursing facility (SNF), residents paying for their stay with private insurance or personal funds, residents on Medicaid, or a combination of the above.

This inspection was conducted as a part of Operation Restore Trust. The initiative, focused in five States, involves multi-disciplinary teams of Federal and State personnel seeking to reduce fraud, waste, and abuse in nursing homes and home health agencies, and by durable medical equipment suppliers.

FINDINGS

Medicare was charged $4.1 billion and Medicare payments of $2.7 billion were made in 1992 for Part B services provided to nursing home residents.

- The most money was spent on physician evaluation services ($894 million), followed by medical equipment, supplies, prosthetics, and orthotics ($772 million).

- More nursing home residents received a physician evaluation service (82 percent of residents) than any other service, followed by laboratory tests (66 percent of residents) and x-rays (47 percent of residents).

The Part B average daily charge varies significantly among both States and nursing homes.

- The State average daily charge ranged from an estimated high of $10.88 in Louisiana to a low of $4.42 in Maine. (The estimated national average was $8.75 per day.)

- Differences between nursing home average daily charges ranged from a low of $1.16 to a high of $49.67. These are sometimes, but not always, explained by differences in the acuity level of the residents treated in the facility.

The accessibility and vulnerability of nursing home residents provide a unique opportunity for fraud, waste, and abuse.

The Medicare Part B program is particularly vulnerable because payment rules and safeguards largely ignore the unique character of the nursing home environment and the varied services and supplies which can be provided. Program vulnerabilities identified include:

- Duplicate Payments: Considered the payer of last resort, it is appropriate for Medicaid agencies to require that providers bill Medicare first for Part B covered services provided to dually eligible nursing home residents. Medicaid pays only for services not covered by Medicare. This overlapping responsibility creates a vulnerability whereby both Medicare and Medicaid could mistakenly pay for the same service or supply when each is unaware the other has paid. To determine the consequences of this vulnerability the OIG is currently conducting an evaluation of duplicate payments.

  Additionally, the shifting of payment responsibility from one program to another can increase overall costs to the taxpayer when the program paying for the service allows reimbursement at a greater rate than would ordinarily be paid by the other program.

- Lack of Oversight: Medicare Part B contractors (carriers and intermediaries) often lack enough information to adequately ensure appropriate payments for residents of nursing homes. For example, carriers generally do not have information that a resident is in a nursing home unless the claim specifically notes the place of service was a nursing home.

- Questionable Supplier or Physician Practices: We have previously documented questionable billing and marketing practices in the provision of incontinence supplies, wound care, and orthotic body jackets to patients in nursing homes. In addition to suppliers, physicians and other practitioners warrant further review for such practices as billing for questionably high numbers of residents on the same day.

CONCLUSION

This review of the utilization of Part B services by nursing home residents suggests the need for further work in many areas such as: 1) examining the appropriateness of consolidated billing of Part B nursing home expenses and the daily rate, 2) monitoring trends in Part B payment utilization over time, 3) evaluating issues of poor quality care resulting from such practices as physicians treating too many patients in one day, exposure to excessive or inappropriate medical services, provision of supplies not medically necessary, etc., and 4) developing and applying various fraud detection methods to identify abusive practices and fraud involving residents of nursing homes.

To support the development of fraud detection methods, further information is currently being gathered on the nature and magnitude of abusive provider practices or program

vulnerabilities involving nursing home residents. This information will be used to identify the most efficient fraud detection methods.

COMMENTS

We thank the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE) for their comments on the draft report. Changes were made based on their suggestions. In addition to suggestions, the HCFA pointed out several actions it has taken to address vulnerabilities such as: 1) requiring carriers and intermediaries to selectively initiate pre-pay reviews on high dollar payment areas and aberrant trends, and 2) development of enhanced duplicate payment detection methodologies for the Medicare Transaction System. The full text of HCFA and ASPE comments are provided in Appendix B.